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Issue Date: 18 March 2005

In the Matter of:

CLAUDE VANDYKE,
Claimant

Case No.: 2003-BLA-213

v.

VANDYKE BROTHERS COAL
COMPANY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Susan D. Oglebay, Esq.
Castlewood, Virginia
For the Claimant

H. Ashby Dickerson, Esq.
Abingdon, Virginia
For the Director

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. §

902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Claude Vandyke, alleges that he is totally disabled by pneumoconiosis.

A hearing was set for this case on November 6, 2003, in Abingdon, Virginia. Because the Claimant was ill, his counsel requested that the hearing be cancelled and a decision be made on the record. The Employer did not object. I granted the Claimant's request in an order dated November 12, 2003. At that time, Director's Exhibits ("DX") 1-140 were admitted into evidence. Pursuant to agreement of the parties, they were given two weeks in which to submit additional evidence. In an order dated December 4, 2003, Claimant's Exhibit ("CX") 1 and Employer's Exhibit ("EX") 1 were admitted into evidence without objection. The record was held open for the parties to submit closing arguments, which were made optional. The Employer filed a closing argument. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits and the arguments of the parties.

PROCEDURAL HISTORY

Mr. Vandyke filed his first claim on August 23, 1971, and after consideration by the Social Security Administration and the Department of Labor, it was finally denied on February 29, 1980. DX 1.

A second claim was filed on September 13, 1983, and denied on August 3, 1984. DX 2.

A third claim was filed on January 22, 1986, and denied May 22, 1986. DX 3. The District Director of the Office of Workers' Compensation Programs ("OWCP") denied that claim on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination.

The current claim was filed August 6, 1987. DX 4. Administrative Law Judge Nicodemo De Gregorio issued a Decision and Order awarding benefits on January 15, 1992. DX 70. He found a material change in conditions pursuant to § 725.309(d) and that, on the merits of the claim, Mr. Vandyke had established that he was totally disabled due to pneumoconiosis arising out of his coal mine employment. The Employer appealed to the Benefits Review Board ("BRB" or "Board"), which vacated Judge De Gregorio's finding of a material change in conditions. DX 79. Judge De Gregorio again found the Claimant entitled to benefits in a July 29, 1996 decision. DX 80. The Board again vacated the finding and remanded for consideration of all the probative evidence since the prior denial. DX 83. On April 8, 1998, Judge Clement J. Kichuk issued a decision on remand, denying benefits on the basis that a material change in conditions had not been established. DX 85.

The Claimant appealed to the Board, but while the appeal was pending, filed a timely request for modification on September 14, 1998. On July 28, 2000, Judge Joseph E. Kane issued a Decision and Order denying benefits pursuant to § 725.310. DX 115. Although he found a change in conditions, pursuant to the employer's stipulation that Mr. Vandyke was totally

disabled, he also found that the Claimant had failed to establish the existence of pneumoconiosis. The Board affirmed in part and vacated in part Judge Kane's denial. The Board directed that Judge Kane revisit his assessment of the biopsy evidence as part of the Claimant's proof of pneumoconiosis. DX 127.

In an opinion dated December 27, 2001, Judge Kane issued a Decision and Order on Remand – Denying Benefits. DX 133. He considered all the biopsy evidence, as well as all of the other evidence bearing on the issue of the presence or absence of pneumoconiosis, and concluded that Mr. Vandyke had failed to establish the existence of pneumoconiosis by a preponderance of the evidence. The Claimant did not appeal Judge Kane's denial to the Board.

On December 27, 2002, the Claimant requested modification of Judge Kane's decision pursuant to 20 CFR § 735.310 (2000). DX 136. The District Director issued a Proposed Decision and Order denying Request for Modification on May 2, 2003. DX 137. The Claimant requested a hearing on May 28, 2003, DX 138, and the claim was referred to this office on June 19, 2003. DX 139.

APPLICABLE STANDARDS

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on August 6, 1987. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2004). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2004). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do not apply to pending cases, see 20 CFR § 725.2(c) (2004). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2004 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that he is entitled to benefits in connection with his current claim, Mr. Vandyke must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, he must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004). I must consider all of the evidence pertaining to his duplicate claim to determine whether there has been a change in conditions or a mistake of fact by Judge Kane; new evidence is not required for me to reach a determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

Because the underlying claim is a duplicate claim, in order to be entitled to benefits, Mr. Vandyke also needs to establish a material change in conditions since his previous claim was denied. 20 CFR § 725.309(d) (2000); see *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996). I agree with Judge Kane that the Employer's concession before him that Mr. Vandyke was totally disabled by a pulmonary or respiratory impairment established a change in conditions since denial of his previous claim. Moreover, all of the pulmonary function studies since 1999, and almost all of the arterial blood gases since that time, have produced values qualifying for disability. Thus the evidence before me also establishes that Mr. Vandyke has been disabled by a pulmonary or respiratory impairment since 1999. In order to establish a change in conditions since Judge Kane's last decision, Mr. Vandyke would need to establish that he has pneumoconiosis. The new evidence submitted in connection with the current request for modification consists of updated treatment records, DX 134 and CX 1, and reports from Dr. Rosenberg and Dr. Halbert issued in September 2003, EX 1. For the reasons stated below, I find that the new evidence does not establish the existence of coal workers' pneumoconiosis. As I have found that the new evidence does not show a change in conditions since Judge Kane's last denial, I will consider the entire record of the current claim to determine whether there has been a mistake of fact.

ISSUES

On the CM 1025, the Employer listed as contested almost every possible issue, including the timeliness of the claim; whether Mr. Vandyke was a miner; whether he worked as a miner after 1969; the length of his coal mine employment; whether he has established the existence of pneumoconiosis; whether his pneumoconiosis arose out of his coal mine employment; whether the miner is totally disabled; whether his total disability is due to pneumoconiosis; whether the employer has secured the payment of benefits through insurance; whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator; and whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. § 725.309(d). DX 139. As I have concluded that the evidence does not establish the existence of pneumoconiosis arising from Mr. Vandyke's coal mine employment, he cannot be entitled to benefits, and I will not expressly address the other issues.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

Mr. Vandyke testified at the hearing before Judge De Gregorio on May 21, 1991. DX 67. He was born in 1923. He has a seventh grade education, and his sole dependent is his wife, Allene. He smoked between one-half and one pack of cigarettes a day for thirty years and suffered from pneumonia in 1970. Mr. Vandyke worked as a coal miner for 28 years. He was employed by Vandyke Brothers Coal Company, Inc., from 1977 to 1985, where, among other things, he worked as a cutting machine helper. In that capacity, he set jacks and moved cables. This required him to lift and carry 50-100 pounds. He was exposed to a lot of dust. His last coal mine employment was in Virginia. DX 5. Therefore this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in the current claim. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). All such readings are therefore included in the "negative" column. Also included in the negative column are x-rays which have been classified as showing opacities in accordance with the ILO-U/C system, but the reader has nonetheless concluded that the opacities seen on the x-ray do not represent coal workers' pneumoconiosis. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, generally given in connection with medical treatment for other conditions, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the List of A and B-Readers issued by the National Institute of Occupational Safety and Health (NIOSH).¹ If no qualifications are noted for any of the following physicians,

¹ NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of

it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A-reader; B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
08/20/69		DX 22 Morgan	
10/30/71		DX 22 Proffitt BCR 0	
03/16/74		DX 107 Scott B, BCR DX 107 Wheeler B, BCR DX 106 Fino B DX 104 Dahhan B	
10/07/83		DX 106 Fino B DX 104 Dahhan B DX 39 Scott B, BCR DX 38 Wheeler B, BCR	
03/25/86		DX 37 Wheeler B, BCR 0/1 DX 36 Scott B, BCR DX 22 Gaziano B 0/1	
12/30/86			DX 65 Mullens BCR (Hyperinflation but otherwise clear)
09/01/87	DX 12 Navani B, BCR 1/2	DX 106 Fino B DX 104 Dahhan B	

NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at <http://www.abms.org>.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
02/22/89		DX 107 Scott B, BCR DX 107 Wheeler B, BCR DX 106 Fino B DX 104 Dahhan B DX 19 Hippensteel B 0/1 DX 19 Castle B 2/2, but do not look like CWP DX 19 Endres-Bercher A	
01/09/91	DX 29, 30 Pathak B, BCR 2/2 DX 29, 30 Cappiello B, BCR 2/1 DX 30 Mathur B, BCR 1/1	DX 44 Dahhan B DX 42, 43 Spitz B, BCR DX 41 Wiot B, BCR DX 40 Pendergrass B, BCR	
07/30/99	DX 100, 101 Coburn B, BCR Unclassified (Interstitial fibrosis in the lungs bilaterally consistent with CWP; numerous other causes could give similar appearance)	DX 108 Wheeler B, BCR DX 108 Scott B, BCR DX 108 Fino B	
10/06/99		DX 107 Scott B, BCR DX 107 Fino B DX 105 Wheeler B, BCR DX 105 Dahhan B	
10/11/99		DX 108 Wheeler B, BCR DX 108 Fino B DX 108 Scott B, BCR	DX 101 Mullens BCR (Chronic reticular interstitial lung disease)
10/27/99		DX 107 McSharry DX 107 Scott B, BCR DX 107 Wheeler B, BCR DX 107 Dahhan B	
01/12/00		DX 110 Fino B DX 110 Scott B, BCR DX 110 Wheeler B, BCR	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
02/07/00		DX 110 Fino B DX 110 Scott B, BCR DX 110 Wheeler B, BCR	
05/06/03			CX 1 Mullens Chronic interstitial lung disease with basilar parenchymal scarring in the right middle and lower lobes. No acute process. No change from 11/14/01.
09/17/03		EX 1 Halbert (B, BCR) 1/2 (increased interstitial markers in the mid and lower lung zones which are consistent with those seen in some types of pneumoconiosis such as asbestosis; not consistent with CWP)	

Biopsies

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2004). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113, 1-114 (1988); see *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that “[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.” One biopsy has been taken in this case; it has been interpreted by several pathologists.

On October 15, 1999, a biopsy specimen was taken from a thoracoscopy of Mr. Vandyke’s left lung performed by Dr. J. Denton at the request of Dr. Emory Robinette. As part of the identifying information at the top of the Surgical Pathology Report, under the heading “Frozen Section Diagnosis,” appears the phrase “Fibrosis and anthracosis” with the initials “RSB,” for Dr. Richard Buddington. Dr. Daniel Hudgens prepared the narrative pathology report. According to the gross description, a wedge of lung tissue was submitted for frozen

section diagnosis. The microscopic description said that interlobular septa, peribronchial connective tissue, and subpleural connective tissue showed mild fibrosis and a moderate degree of deposition of black pigment. There was focal emphysematous change. The diagnosis was, "Lung, left, biopsy: features consistent with simple coal workers pneumoconiosis." DX 101.

Dr. Joseph Tomashefski, a board certified pathologist and professor of pathology at Case Western Reserve University, reviewed Mr. Vandyke's medical records and the slides from the October 1999 thoracoscopic lung biopsy specimen. DX 109. His review of the slides showed black pigment and fibrosis, but no coal macules or micronodules. He diagnosed diffuse panacinar emphysema, but based on the absence of coal macules, he said Mr. Vandyke did not have coal workers' pneumoconiosis. The black pigment represented only coal dust exposure. He also opined that Mr. Vandyke did not have significant interstitial fibrosis. He said the interstitial changes reported on the chest x-rays and CT scans probably represented pleural and interlobular septal fibrosis in association with focal atelectasis, probably a secondary reaction to pleural fibrosis and chronic atelectasis. He said the pulmonary function tests demonstrating obstruction with increased lung volumes supported the diagnosis of emphysema, rather than interstitial fibrosis. Reversibility with administration of bronchodilators was consistent with the added diagnosis of asthmatic bronchitis, which is not caused by coal dust exposure. Dr. Tomashefski also noted the decline in Mr. Vandyke's pulmonary function after he ceased coal mine work, saying that simple coal workers' pneumoconiosis does not usually progress after exposure to coal dust ceases. Based on the lung biopsy, he concluded that Mr. Vandyke had panacinar emphysema caused by cigarette smoking, and that coal dust exposure did not cause any impairment or symptoms.

Dr. Erika Crouch, a board certified anatomic pathologist and professor of pathology at Washington University in St. Louis, examined the slides and reviewed the pathology report by Dr. Hudgins from October 1999 on behalf of the Employer. DX 111. Dr. Crouch diagnosed emphysema, predominant panacinar; chronic bronchiolitis; non-specific remodeling of pulmonary arteries; and no evidence of coal workers' pneumoconiosis. In her explanatory comment, she stated:

Although there is histologic evidence of coal dust accumulation in the lung, no diagnostic coal dust macules are identified, and no coal dust micronodules, nodules or areas of massive fibrosis or silicotic nodules are observed. There is histologic evidence [of] panacinar emphysema, and some small airway profiles show irregular luminal contours with variable mural fibrosis and patchy infiltrates of chronic inflammatory cells consistent with a chronic bronchiolitis. Although the changes are non-specific there is no evidence to suggest that they are any way related to coal dust deposition. The pulmonary artery changes are suggestive of some degree of pulmonary hypertension; however, similar medial and intimal remodeling can be observed in elderly patients without significant other lung disease.

In summary, there is no histologic evidence of simple coal workers' pneumoconiosis. The majority of the particulates within the lung are derived from cigarette smoke, and the observed panacinar emphysema is unrelated to coal dust deposition. The etiology of the bronchiolitis is uncertain, but there is no pathologic evidence to suggest a relationship to

coal deposition. Thus, occupational coal dust exposure cannot be implicated as a causal factor in any clinically evident respiratory impairment.

DX 111 at 2.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33-1-34 (1991).

In connection with his initial examination of Mr. Vandyke for treatment, Dr. Emory Robinette ordered a CT scan of Mr. Vandyke's chest which was taken on July 30, 1999. The radiologist, Dr. Ernest Coburn, gave the following impression:

1. Diffuse interstitial process throughout the lung fields greatest in the mid to lower lung zones with honeycombing in the lower lung zones. Etiology of this is unknown. It may be secondary to occupational exposure. ...

DX 100, 101.

Dr. William Scott, a board certified radiologist and B reader, interpreted the July 30, 1999, CT scan to show non-specific linear interstitial fibrosis with honeycombing posterior lung bases, probably UIP [usual interstitial pneumonitis], and emphysema, with no evidence of silicosis/CWP [coal workers' pneumoconiosis]. DX 108.

Dr. Paul Wheeler, a board certified radiologist and B reader, also interpreted the July 30, 1999, CT scan to show emphysema and minimal interstitial fibrosis, but no pneumoconiosis. DX 108.

Dr. Gregory Fino, a pulmonologist and B reader, also reviewed the July 30, 1999, CT scan on behalf of the Employer. DX 108. He said there were no changes consistent with a coal mine dust associated occupational lung disease. He thought the interstitial infiltrates in the lung bases might indicate idiopathic pulmonary fibrosis.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. “Pre” and “post” refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a “qualifying” pulmonary study, the FEV₁ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV₁/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Date Physician	Age Height	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 22 03/25/86 Paranthaman	63 68”	2.61	4.53	58%	114	No	Within normal limits
DX 12 09/01/87 Garcia	64 68”	2.64	5.12	52%	96.9	No	Normal
DX 19 02/22/89 Endres- Bercher	66 68”	2.12 2.48	3.58 3.83	59% 65%	105 107	No No	Mild obstructive deficit, improvement to normal with bronchodilators; no restriction.
DX 30 12/17/90 Forehand	67 68”	2.46	4.55	54%		No	
DX 35, 46 04/10/91 Buddington	68 67.25” ²	2.25	3.98	57%	84	No	Slight obstructive impairment. Invalid per Fino, DX 63.
DX 101 08/09/99 Robinette	76 66”	1.21 1.37	2.83 3.01	43% 45%		Yes Yes	Moderate obstructive disease, without response to bronchodilator.

² The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 66” to 68”, I have taken the mid-point (67”) in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 101 10/11/99 Robinette	76 66"	.97 1.31	2.20 2.70	44% 48%		Yes Yes	Deterioration of function compared to previous study. Worsening interstitial pulmonary fibrosis with progressive restrictive and obstructive disease which responds to bronchodilator.
DX 107 10/27/99 McSharry	76 69"	1.01 1.21	2.74 3.09	36% 39%	32	Yes Yes	Severe obstructive disease, partly reversible
DX 102, 103, 113 11/16/99 Robinette	76 66"	.91 .94	2.48 2.46	37% 38%		Yes Yes	No response to bronchodilator. Deterioration of lung function.
EX 1 09/17/04 Rosenberg	80 59"	.93	3.17	29%	21	Yes	Severe obstruction. No restriction.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO₂) and the percentage of carbon dioxide (PCO₂) in the blood. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO ₂ at rest/ exercise	PO ₂ at rest/ exercise	Qualify?	Physician Impression
DX 22	03/25/86	Paranthaman	36.8 38.3	67.6 73.1	No No	Moderate resting hypoxemia. Slight improvement during exercise.
DX 12	09/01/87	Garcia	37.3 35.7	66.0 84.1	No No	Moderate resting hypoxemia. Increased with exercise.
DX 19	02/22/89	Endres-Bercher	31.1 31.9	75.0 72.7	No No	Mild hypoxemia at rest and with exercise
DX 35	04/10/91	Buddington	33	61	Yes	Hypoxemia with hyperventilation
DX 101	08/09/99	Robinette	39.7	55	Yes	Intercurrent hypoxemia.
DX 101	10/11/99	Robinette	38.4	60.0	Yes	
DX 107	10/27/99	McSharry	38	61	Yes	Mild hypoxemia for age
DX 102	11/16/99	Robinette	36.5	56.0	Yes	
EX 1	09/17/03	Rosenberg	38.0	66.3	No	Reduced oxygenation

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

The Employer introduced records from Mr. Vandyke's hospitalization for uremia in December 1986. According to the discharge summary from Johnston Memorial Hospital, his general health was reported as satisfactory, with no routine medications or past serious illnesses, and his chest x-ray was grossly normal. DX 19.

Dr. J. Garcia examined Mr. Vandyke on behalf of the Department of Labor on September 1, 1987. DX 12. Dr. Garcia's qualifications are not in the record; his address was given as the Respiratory Disease Clinic at Lonesome Pine Hospital in Big Stone Gap, Virginia. He took

occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Vandyke worked in the mines for 30 to 35 years. He reported a smoking history of 1/2 pack per day for 35 years. The chest examination revealed a slight increase in AP diameter, and reduced breath sounds bilaterally with dry rales which did not change with cough. There was very slight clubbing of the fingers. Dr. Shiv Navani, a board certified radiologist and B reader, read the x-ray as showing changes of pneumoconiosis in all lung zones, p/p, profusion 1/2. The pulmonary function test was normal. The arterial blood gas study revealed hypoxemia at rest. Dr. Garcia diagnosed early coal workers' pneumoconiosis based on the history of dust exposure, physical findings, x-ray and resting hypoxemia.

Dr. John Endres-Bercher examined Mr. Vandyke on behalf of the Employer on February 22, 1989. DX 19. Dr. Endres-Bercher is board-certified in internal medicine, and an A reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Vandyke worked in the mines for 32 years. He reported a smoking history of 1/2 to one pack per day from age 24 to age 65. The chest examination was normal. Dr. Castle, a B reader, read the x-ray as showing s/s opacities in the middle and lower lung zones, profusion 2/2. Both Dr. Castle and Dr. Endres-Bercher said the opacities were not consistent with coal workers' pneumoconiosis. The pulmonary function test showed mild obstructive deficit with improvement with bronchodilator, and no restrictive impairment. The arterial blood gas study revealed mild hypoxemia at rest and with exercise. Dr. Endres-Bercher diagnosed chronic obstructive lung disease with probable chronic bronchitis. Based upon his examination and test results, Dr. Endres-Bercher concluded that Mr. Vandyke was not suffering from coal worker's pneumoconiosis. In his opinion, the pulmonary function and blood gas studies and chest x-ray were more consistent with obstructive lung disease accompanied by chronic bronchitis due to smoking than with pneumoconiosis, which is a restrictive disorder. Dr. Endres-Bercher opined that Mr. Vandyke would not be able to sustain prolonged heavy labor, but would be able to perform periodic strenuous labor such as he performed in his last job in the mines.

In a deposition taken on August 1, 1989, Dr. Endres-Bercher testified regarding his examination of February 22, 1989. DX 19. Dr. Endres-Bercher reiterated the opinion he gave at the time of the examination. In addition, he stated that pneumoconiosis is an interstitial disease and classically causes a restrictive impairment without improvement on bronchodilator, decreased lung volumes, and decreased diffusion capacity. Mr. Vandyke had a mild obstruction which improved with bronchodilators, which Dr. Endres-Bercher reiterated was due to exposure to tobacco smoke. The mild hypoxia at rest and with exercise was not in a significant range, and was also consistent with cigarette smoking. He said the irregular opacities seen in the chest x-ray were consistent with bronchitis and other interstitial processes, rather than the round opacities of coal workers' pneumoconiosis, although he said on cross examination that the irregular opacities can also be seen in coal miners as a result of other types of dust they come into contact with. He had also identified possible pneumonitis on the x-ray, which can be caused by idiopathic "usual" or "diffuse" interstitial pneumonitis, or many other exposures to organic or inorganic dust or particles. Dr. Endres-Bercher did not believe that Mr. Vandyke was disabled, as he could perform intermittent heavy labor, but not sustain it without interruption for an eight-hour day. Asked to compare the results of various studies, Dr. Endres-Bercher said Mr.

Vandyke's decline in performance could result from continued smoking and aging. Asked on cross examination about the effect returning to the mines would have on Mr. Vandyke, Dr. Endres-Bercher could not say.

Dr. Richard Buddington examined Mr. Vandyke at the request of his counsel on April 10, 1991. DX 35. Dr. Buddington is board certified as a medical examiner and anatomical and clinical pathologist. DX 35, 59. He took occupational, social, family and medical histories, and conducted a physical examination, blood gas studies and pulmonary function testing. He reported that Mr. Vandyke worked in the mines for over 30 years, not all of which were documented. He reported a 35 pack-year smoking history. The chest examination revealed an increased A/P diameter, and the lungs were hyper-resonant to percussion. The pulmonary function test and arterial blood gas study were abnormal.³ Dr. Buddington diagnosed moderate to severe chronic respiratory disease and chest pain, etiology undetermined. He assessed a moderate to severe impairment based on history and physical and the results of the arterial blood gas and ventilatory studies. He said that the degree of impairment indicated that Mr. Vandyke might have dyspnea at rest, and would have dyspnea during the usual activities of daily living. He would be unable to perform heavy labor. Dr. Buddington added, "The patient has over thirty years of mining exposure. I think it is medically reasonable to assume that the patient's primary pulmonary disorder is coal workers' pneumoconiosis ..."

Dr. Gregory Fino reviewed medical records on behalf of the Employer on several occasions. Dr. Fino is board certified in internal medicine and pulmonary disease, and a B reader. DX 60. His initial report was issued on April 29, 1991. DX 45. He reviewed x-rays, medical reports, and pulmonary function and arterial blood gas studies from 1971 to 1991. He concluded based on pulmonary function tests, normal diffusing capacities, and arterial blood gases, that although Mr. Vandyke had some slowing of flow in his large and small airways consistent with the effects of smoking, he had no respiratory impairment, and retained the capacity to perform his last mining job, including continuous labor. Despite positive x-ray readings, he believed that taking all the readings into consideration, the changes were more consistent with cigarette smoking than coal dust inhalation, with a disproportionate reduction in flow of small airways compared to flow in large airways; no restrictive ventilatory defect; no reduction in diffusing capacity; increased lung volumes; and reversibility following administration of bronchodilators. Taking all these factors into account, Dr. Fino did not believe Mr. Vandyke had an occupationally acquired pulmonary condition.

In a supplemental report dated May 1, 1991, Dr. Fino reported that he had reviewed additional records, including the examination by Dr. Buddington. DX 63. Dr. Fino said the pulmonary function study was technically invalid, but the values were within normal limits, and better effort would have given higher values. He said the arterial blood gas showed mild hypoxia. He disagreed with Dr. Buddington's conclusion that Mr. Vandyke had a moderate to severe chronic respiratory impairment, as there was no valid objective evidence of it. Dr. Fino said variations in the resting blood gases were consistent with continued smoking. Dr. Fino did

³ According to Dr. McSharry, Dr. Buddington used the wrong data for the results of the pulmonary function test in his evidence summary (calibration values rather than test results). DX 107 (EX 20 at 2).

not change any of his original conclusions.

Dr. J. Randolph Forehand treated Mr. Vandyke from March 1993 to July 1998, seeing him about every six months. Dr. Forehand is board certified in allergy and immunology, and pediatrics. His treatment records are found in DX 87. They reflect that Dr. Forehand was treating Mr. Vandyke for coal workers' pneumoconiosis, chronic bronchitis, sinusitis and COPD [chronic obstructive pulmonary disease]. By 1994, Mr. Vandyke was using oxygen while sleeping. Dr. Forehand occasionally reported diminished breath sounds and inspiratory crackles on examination at first, and then consistently in 1997 and 1998.

Dr. Forehand wrote a report to the Claimant's counsel on November 16, 1998. He had been treating Mr. Vandyke since March 31, 1993, and had reviewed his chart. He reported 32 years of coal mine work ending at age 62 in 1985, and a smoking history of 45 years. When he first saw Mr. Vandyke, chest x-ray revealed hyperinflation and irregular opacities at the bases. His pulmonary function test results did not meet disability standards, but his blood gas study did. Dr. Forehand believed that Mr. Vandyke had coal workers' pneumoconiosis, but said his lack of credentials might hurt Mr. Vandyke's claim. DX 92.

Dr. Emory H. Robinette, who is board certified in internal medicine and pulmonary disease, began seeing Mr. Vandyke on July 28, 1999, upon referral due to his increasing respiratory symptoms. At his initial examination, Dr. Robinette took medical, social, occupational and family histories, and conducted a physical examination. He reported a 20 pack-year smoking history, and 20 years of mining employment. Examination of the chest revealed decreased breath sounds with bilateral inspiratory crackles in all lung zones. He scheduled Mr. Vandyke for a CT scan of his chest, among other tests, which revealed bilateral interstitial fibrosis consistent with coal worker's pneumoconiosis or other causes. Dr. Robinette diagnosed bilateral pulmonary fibrosis. He anticipated rapid deterioration of Mr. Vandyke's lung function. CX 1; DX 100, 101, 102, 134.

Mr. Vandyke returned to Dr. Robinette on August 9, 1999. Dr. Robinette interpreted the pulmonary function and arterial blood gas studies to be consistent with moderate obstructive lung disease with evidence of air trapping, severe impairment of diffusion capacity and hypoxemia. He said that clinically there was evidence of interstitial fibrosis of unknown etiology, most likely due to coal workers' pneumoconiosis, but possibly associated with an active inflammatory condition. DX 101.

After review of the initial diagnostic studies, on October 11, 1999, Dr. Robinette referred Mr. Vandyke for a biopsy. DX 101. The biopsy report is discussed above.

Dr. Roger McSharry examined Mr. Vandyke on behalf of the Employer on October 29, 1999. DX 107. Dr. McSharry is board-certified in internal medicine and pulmonary disease, and critical care medicine. Mr. Vandyke had first appeared on October 6, but was ill with pneumonia, so Dr. McSharry treated him and referred him to his own doctor, Dr. Robinette, for follow-up. When Mr. Vandyke returned on October 29, Dr. McSharry took occupational, social, family and medical histories, reviewed records provided by counsel, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies and pulmonary function testing.

He reported that Mr. Vandyke worked in the mines for 20 years. He reported a smoking history of 1/3 pack per day for 20 years out of the period from his late twenties into his early seventies due to long periods of abstinence. There was clubbing at the fingers, and chest examination revealed an increased AP diameter and crackles above both lung bases, suggesting interstitial lung disease. Dr. McSharry read the x-ray as showing increased basilar markings without changes of pneumoconiosis. He also referred to the negative readings by Drs. Scott and Wheeler. The pulmonary function test showed severe airflow obstruction and air trapping. The diffusion capacity was mildly reduced. There was "excellent" improvement with bronchodilators. The arterial blood gas study revealed moderate hypoxemia for age, but was outside disability range. Based in part on the pulmonary function tests and chest x-rays, Dr. McSharry concluded that Mr. Vandyke was not suffering from coal worker's pneumoconiosis. Dr. McSharry thought the hypoxemia might be due to obstructive disease and recent pneumonia. In his opinion, Mr. Vandyke was suffering from asthma, chronic bronchitis and emphysema. He went on to state, "If the abnormality in lung function was due to coal worker's pneumoconiosis, unmistakable x-ray changes of pneumoconiosis would necessary [sic] be seen." DX 107 (EX 20 at 2). His opinion was reinforced by his review of Mr. Vandyke's medical records. Although the chest x-rays were abnormal, he thought they represented interstitial lung disease, unrelated to coal dust exposure, which had progressed over the years. The pulmonary function tests would be expected with severe obstructive disease related to cigarette abuse. Reversible air flow obstruction could result from untreated asthma. He did not have the 1999 biopsy reports, but said the "presence of anthracosis (coal pigments on the biopsy) ... merely indicates exposure to inhaled coal dust, not pneumoconiosis. DX 107 (EX 20 at 3). Although he did not think there was evidence of coal worker's pneumoconiosis, there was a severe respiratory impairment due to asthma and smoking. He said Mr. Vandyke was disabled from his previous coal mine work, or any strenuous or moderately strenuous work.

Dr. Robinette requested additional pulmonary function tests in November 1999. The results are reported on the table above. Upon reviewing the results during Mr. Vandyke's December 27 follow-up visit for "underlying fibrosis with black lung disease," Dr. Robinette observed that his lung function had declined. DX 102, 103, 113.

Dr. Fino again reviewed records on behalf of the Employer, including chest x-ray and CT scan readings, pathology reports, pulmonary function tests, blood gases, office and examination records from 1971 to 2000, and prepared a report dated March 22, 2000. DX 112. Dr. Fino said each disease and condition mentioned in the statutory definition of pneumoconiosis manifests different clinical and pathologic signs and characteristics, such that generalizations cannot be made about it. He said that only after a specific diagnosis has been made can a doctor determine whether there is an impairment present, and if so, the cause. He opined that Mr. Vandyke does not suffer from an occupationally acquired pulmonary condition as a result of coal dust exposure based on x-rays, pathology, spirometric evaluations, diffusing capacity, and oxygen transfer. As to the x-rays, he said the majority of the readings were negative, and recent interstitial irregular abnormalities seen in the lower lung zones were inconsistent with coal workers' pneumoconiosis, which would show rounded opacities first affecting the upper lung zones. As to the pathology, he said the prosector did not describe any of the classic changes of coal workers' pneumoconiosis such as coal dust macules, perifocal emphysema, and mild scarring around the perifocal emphysema. Spirometric evaluations showed obstruction in the absence of any

interstitial abnormality and involvement in the small airways, not consistent with coal dust related conditions, but consistent with such conditions as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis and asthma. He said obstructive disease may arise from coal workers' pneumoconiosis in the presence of significant fibrosis, not seen here. Normal diffusing capacity, recently reduced, and the absence of impairment in oxygen transfer, were also inconsistent with coal workers' pneumoconiosis. Dr. Fino observed that hundreds of different diseases, including non-pulmonary conditions, can produce the same symptoms and physical findings as pneumoconiosis.

Dr. Fino said there had been a significant change in Mr. Vandyke's overall condition between 1990 and 1999, when he continued to smoke, but was no longer exposed to coal dust. His records showed reduced FEV₁, diffuse interstitial changes in the lower lungs, significant resting hypoxia, decrease in diffusing capacity, and lung volumes previously elevated but now normal, indicating a combined obstructive and restrictive defect. Taking all of this information into account, Dr. Fino believed Mr. Vandyke had ongoing cigarette smoking induced centriacinar emphysema and obstruction, and, in addition, had developed a diffuse interstitial pulmonary fibrosis, which is not a condition caused by the inhalation of coal dust. In his view, the findings did not represent progression of pneumoconiosis. Dr. Fino cited various publications in support of his opinions. He said the literature does not support the statement that coal workers' pneumoconiosis is progressive absent further exposure; that it is possible to differentiate the obstruction caused by coal mine dust from the obstruction caused by other factors such as smoking and asthma; and that obstruction in miners is not clinically significant. He criticized studies connecting reduced FEV₁ with coal dust exposure as flawed because of selection bias or methodology. Dr. Fino concluded by emphatically stating that Mr. Vandyke's condition would be not different had he never stepped foot in the mines.

Dr. Robinette's notes from 2001 show that Mr. Vandyke suffered from pneumonia that resolved by June 29, 2001. In August of that year, he had no new problems. The typewritten assessments show that Dr. Robinette followed Mr. Vandyke for his "underlying pulmonary fibrosis, DVT and history of hypoprothrombinemia." Examination of the chest showed that it was clear on auscultation with diminished breath sounds and bilateral crackles in both bases. DX 134.

Dr. Robinette attended Mr. Vandyke during a November 14-16, 2001 admission at Johnson Memorial Hospital. Mr. Vandyke presented with malaise, weakness, fever, increasing cough, dyspnea, increased sputum production, and urinary pain and frequency and was admitted for treatment of the pneumonia and urinary tract infection. Dr. Robinette considered a medical history significant for black lung disease with associated pleural pulmonary fibrosis, a history of urinary tract infections, allergic-induced urticaria with near upper airway obstruction, and septic thrombophlebitis. He referenced past pulmonary function study results, CT scans that showed evidence of interstitial fibrosis with honeycombing, and the lung biopsy that evinced interstitial fibrosis with dust reticulation and emphysema. Dr. Robinette considered a 30-pack-year smoking history ending in 1997 and Mr. Vandyke's status as a retired coal miner, although length of employment was not given. Physical examination revealed bilateral inspiratory crackles, wheezes, and marked prolongation of the expiratory phase. Blood work was ordered. Chest x-ray showed evidence of chronic interstitial lung disease in the lateral bases, and a blood

gas study was performed. Dr. Robinette diagnosed: (1) probable recurrent pneumonia superimposed on underlying black lung disease and pulmonary fibrosis; (2) possible recurrent urinary tract infection; (3) history of recurrent thrombophlebitis requiring chronic anticoagulation therapy; (4) history of recurrent urticaria associated with upper airway obstruction; and (5) benign prostatic hypertrophy. DX 134.

In January and April 2002, Dr. Robinette's office notes explained that Mr. Vandyke was being followed for phlebitis, and "CWP/COPD" but no new problems. Mr. Vandyke complained of wheezing in April, and Dr. Robinette heard diminished breath sounds with scattered rhonchi and a prolongation of the expiratory phase. By October 2002, Dr. Robinette referred to a "history of components of cor pulmonale with chronic diuretic therapy." Physical examination revealed diminished breath sounds but his inspiratory crackles had decreased significantly since the prior examination. DX 134.

Dr. Robinette continued to follow Mr. Vandyke in 2003, for black lung disease, COPD and a history of phlebitis. In January 2003, Mr. Vandyke had no significant change in his shortness of breath, and physical examination revealed diminished breath sounds with a few inspiratory crackles in both bases. The same findings were made in May and August 2003, with Mr. Vandyke reporting profound dyspnea on minimal exertion. Dr. Robinette expressed concern that Mr. Vandyke had lost a significant amount of weight. CX 1.

Dr. David M. Rosenberg, who is board certified in internal medicine and pulmonary disease, examined Mr. Vandyke on behalf of the Employer on September 17, 2003, and reviewed records from 1971-2003. EX 1. He considered symptoms of breathing difficulties for over twenty years, currently using oxygen 24 hours a day, and a productive cough, especially at night; a medical history notable for hospitalizations for breathing difficulties; a history of smoking less than a pack of cigarettes a day for about thirty years; and around thirty years of coal mine employment, lastly as a joy loader, loading coal into cars and lifting up to fifty pounds. Physical examination revealed markedly hyperresonant chest with markedly diminished breath sounds and scattered rhonchi. Dr. Rosenberg considered the results of a blood gas study, an EKG, a pulmonary function study, and the x-ray read by Dr. Halbert. He said that the pulmonary function tests were performed with difficulty because of severe shortness of breath, and that although maximal efforts may not have been achieved, the results suggested severe airflow obstruction. There was no restriction. Diffusing capacity was severely reduced, and air trapping was present. His review of the medical evidence included x-rays taken between September 21, 1971 and February 2000; pulmonary function studies conducted between October 7, 1983 and December 27, 1999; blood gas studies dated between October 7, 1983 and November 16, 1999; the October 15, 1999 pathology report; hospital records; the office notes, evaluations, and/or reports of Drs. Kanwal, Paranthaman, Endres-Bercher, Garcia, Buddington, Fino, Forehand, Robinette, McSharry, Crouch, and Tomashefski; CT scan reports; and the deposition of Dr. Endres-Bercher. Dr. Rosenberg concluded that Mr. Vandyke had underlying severe chronic obstructive pulmonary disease with asbestosis or another form of linear interstitial lung disease such as idiopathic pulmonary fibrosis ("IPF") or usual interstitial pneumonitis. He opined that Mr. Vandyke did not have coal workers' pneumoconiosis.

Dr. Rosenberg relied upon the following factors in reaching his conclusion: marked

hyperresonance, decreased breath sounds, and rhonchi are findings of severe chronic obstructive pulmonary disease; x-rays revealed an emphysematous pattern, especially in the upper lung fields, with interstitial linear changes in the lower lobe; x-rays did not show micronodularity in the upper lung zones consistent with coal mine dust exposure; the 1999 CT scan did not describe micronodularity; and Dr. Tomashefski, a pathologist, did not find coal macules or micronodularity when he examined the pathology slides. Dr. Rosenberg opined that the lower lobe interstitial linear changes are related to compression from Mr. Vandyke's upper lung field emphysematous abnormalities and some primary linear interstitial lung disease such as asbestosis or IPF [idiopathic pulmonary fibrosis], but not coal mine dust inhalation.

Dr. Rosenberg said that Mr. Vandyke was disabled from any form of employment because of severe airflow obstruction and decreased diffusing capacity as a result of underlying chronic obstructive pulmonary disease with a component of a linear form of interstitial lung disease. He made clear his belief that coal mine dust exposure can cause COPD but explained why that was not the case here:

With the development of CWP in the lung, coal is deposited in the terminal bronchiole and a coal macule is formed. Associated with this coal macule, focal emphysema can develop. As the macule potentially evolves into micronodular or macronodular and eventually complicated CWP (in a susceptible individual), there is potential for this underlying COPD to progress. In Mr. Vandyke's situation, with the finding of severe emphysema (panacinar as noted by Dr. Tomashefski) without micronodularity, it would be improbable that his obstructive lung disease and disability relate to or have been hastened by the past inhalation of coal mine dust. Undoubtedly, it relates to his long smoking history.

Dr. Rosenberg concluded that Mr. Vandyke had severe chronic obstructive pulmonary disease, with asbestosis or another form of linear interstitial lung disease, but no coal workers' pneumoconiosis or any impairment caused or hastened by past inhalation of coal mine dust.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004). In this case, Mr. Vandyke’s medical records indicate that he has been diagnosed with coal workers’ pneumoconiosis, as well as chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. *Ibid.*; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2004), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis and that a miner’s death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the claim was filed after January 1, 1982, and Mr. Vandyke is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays, biopsy evidence, and medical opinions. Absent contrary evidence, evidence relevant to any category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn*

Coal Corp., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, above at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Two x-rays have been submitted in connection with the pending request for modification. The first, taken May 6, 2003 in connection with treatment, mentions chronic interstitial lung disease with parenchymal scarring, but does not identify coal workers' pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). As the x-ray is not entirely negative, I find that it is neither positive nor negative. The second, taken September 17, 2003, is negative. Although the radiologist, Dr. Halbert, classified it as profusion 1/2 in accordance with the ILO-U/C International Classification of Radiographs, he said it was not consistent with coal workers' pneumoconiosis. As neither x-ray is positive for pneumoconiosis, the new x-rays do not show a change in conditions.

Looking at all of the x-ray evidence in the duplicate claim, of the 17 x-rays with readings in the record, only three (those taken September 1, 1987, January 9, 1991 and July 30, 1999) have been read as positive by any readers, and all three have also been read as negative by well-qualified readers. At best, they are in equipoise. The remaining 14 are negative, except for 3 taken in connection with treatment which I find are neither positive nor negative. The overwhelming weight of the x-ray evidence is therefore negative. Thus Mr. Vandyke cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

No new biopsy evidence was submitted in connection with the request for modification. As to the biopsy evidence previously submitted, Dr. Buddington, a board certified pathologist, diagnosed "fibrosis and anthracosis," and Dr. Hudgens, also a board certified pathologist, said there were "features consistent with simple coal workers pneumoconiosis." Neither offered any explanation as to why they diagnosed anthracosis or coal workers' pneumoconiosis, either of which would meet the regulatory definition of pneumoconiosis. In contrast, both Dr. Tomaszewski and Dr. Crouch, who are board certified pathologists, and hold academic appointments, explained in detail why they interpreted the specimen to show coal dust exposure, but not coal workers' pneumoconiosis. As their opinions are better explained, I give them greater weight. I conclude that the biopsy findings reflect only black pigmentation, which is insufficient to establish the existence of pneumoconiosis under the regulations. Thus I find no mistake in Judge Kane's similar conclusion.

I must next consider the medical opinions and other probative evidence. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items

such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of a physician are relevant in assessing the probative values to which his opinion is entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with Mr. Vandyke's condition than a physician who examines him episodically. *Ondecko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).

First, in order to determine whether Mr. Vandyke has established a change in conditions since Judge Kane's denial, I considered just the medical opinion evidence submitted in connection with the request for modification, that is, Dr. Robinette's treatment records since 2001, and Dr. Rosenberg's examination and review of records in 2003. Dr. Robinette diagnosed black lung disease, while Dr. Rosenberg did not. Several factors affected the weight I placed on these two opinions.

Dr. Robinette is Mr. Vandyke's treating physician, having first examined him in July 1999. The new records confirm that he has seen Mr. Vandyke on ten occasions between 2001 and 2003, and that he was the admitting physician for a November 2001 hospitalization for pneumonia. Dr. Robinette has prescribed medication to assist Mr. Vandyke's breathing. I find that he is especially well acquainted with Mr. Vandyke's condition. In the newly submitted records, Dr. Robinette considered some objective test results such as an x-ray, blood gas study, and pulmonary function study. In the main, however, it appears that he was also relying on his earlier diagnostic tests and treatment of Mr. Vandyke, already in the record before Judge Kane. I place great weight on his opinion, but not controlling weight because, as discussed below, I find Dr. Rosenberg's contrary opinion better reasoned.

Dr. Rosenberg's opinion is based not only on his own examination of Mr. Vandyke but also a review of all the medical evidence of record. There is no indication that Dr. Robinette was ever provided with all of the records. Thus, Dr. Rosenberg had an extremely broad base of data

from which to draw his conclusions, much of which was not available to Dr. Robinette, and I accord greater weight to an opinion which is supported by more extensive documentation. *Sabett v. Director, OWCP*, 7 BLR 1-299 (1984). I also find his opinion better supported by the objective medical data, namely the x-rays, CT scan reports, and biopsy evidence. *Minnich v. Pagnotti Enterprises, Inc.*, 9 BLR 1-89, 1-90 n. 1 (1986). His examination of Mr. Vandyke was thorough, and the conclusions he drew were well documented and reasoned. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Dr. Rosenberg explained that Mr. Vandyke's clinical presentation was characteristic of severe COPD not related to coal mine employment. By contrast, Dr. Robinette offered no explanation why he attributed Mr. Vandyke's signs and symptoms to coal workers' pneumoconiosis rather than smoking, or how the two possible sources of disease might have interacted. Dr. Rosenberg stated that coal workers' pneumoconiosis appears as nodules in the upper lung zones, whereas Mr. Vandyke's lung disease exhibited scarring in the mid and lower zones. He further opined that the emphysematous pattern found in the upper lung zones caused compression of and interstitial linear changes in the lower lobes. Finally, Dr. Rosenberg cogently explained why Mr. Vandyke's COPD is due to smoking and not coal mine dust inhalation. For these reasons, I placed greater weight on Dr. Rosenberg's opinion in determining that Mr. Vandyke had failed to establish changed conditions, i.e., the existence of pneumoconiosis, with the newly submitted evidence.

Finally I weighed all of the medical opinion evidence to determine whether Mr. Vandyke had shown that Judge Kane made a mistake in a determination of fact on this issue. Every physician who has examined Mr. Vandyke or reviewed his records since 1987 has agreed that he has a pulmonary or respiratory impairment. Dr. Garcia, Dr. Buddington, Dr. Forehand and Dr. Robinette believe that his impairment is related to his coal mine employment. Dr. Endres-Bercher, Dr. Fino, Dr. McSharry and Dr. Rosenberg disagree with that assessment. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions.

Despite the fact that all the opinions are documented and reasoned, many raise questions as to the weight they should be given. Among those in favor of a diagnosis of pneumoconiosis, Dr. Garcia's opinion was rendered early in the course of Mr. Vandyke's illness, was based on very limited information, and relied in part on a positive x-ray reading, while I have found the weight of the x-ray evidence to be negative. Dr. Buddington is a pathologist, rather than a pulmonologist. At the time he gave his initial opinion, no biopsy had been taken. His opinion is undermined by his assessment that Mr. Vandyke had a disabling impairment by 1991, which is not supported by the objective evidence. More importantly, his opinion as to the cause of Mr. Vandyke's pulmonary impairment in 1991 was explicitly based on an assumption due to Mr. Vandyke's 30-year history of exposure to coal dust, rather than a rigorous analysis of the evidence; and his 1999 diagnosis of anthracosis is unexplained. Although less explicitly stated, it appears that Dr. Forehand, too, assumed coal dust was the cause, and he also lacks the credentials of the best qualified doctors, as he is not a pulmonologist. The strongest opinion in favor of a finding of pneumoconiosis is that of Dr. Robinette, who, as is noted above, is a pulmonologist, and, as Mr. Vandyke's treating physician, knows him well. Even Dr. Robinette's interpretation of the CT scan he ordered was inconclusive, however, as he said the interstitial fibrosis it revealed was consistent with coal workers' pneumoconiosis "or other causes." The

radiologist who initially interpreted the CT scan said the etiology of the fibrosis was unknown, but “may be secondary to occupational exposure,” while two dually qualified readers (Drs. Scott and Wheeler) and a pulmonologist and B reader (Dr. Fino) said the CT scan did not show pneumoconiosis. I have already found that the biopsy did not establish the existence of pneumoconiosis either. Nonetheless, Dr. Robinette’s opinion that Mr. Vandyke’s lung disease is related to coal dust exposure is entitled to great weight.

Ultimately, however, the same factors which led me to give greater weight to Dr. Rosenberg’s opinion when considering whether there has been a material change in conditions, also apply when considering whether there has been a mistake in a determination of fact. That is, of all the doctors giving an opinion, he has qualifications matching those of Dr. Robinette, he had the most information available to him, and he gave the most detailed and thorough explanation of the reasons he reached the conclusions that he did. In addition, his opinion is well supported by Dr. McSharry, who is also a pulmonologist, and had the opportunity to examine Mr. Vandyke, and review his records. Both Dr. Rosenberg and Dr. McSharry attribute Mr. Vandyke’s lung impairment to causes other than coal dust. Their opinions are bolstered by Dr. Fino and Dr. Endres-Bercher, although I give less weight to their opinions, as they appear to have focused on the absence of “clinical” pneumoconiosis causing restrictive disease, to the exclusion of “legal” pneumoconiosis, which the regulations explicitly acknowledge to include obstructive disease arising out of coal mine employment. In addition, many of the opinions expressed by Dr. Fino in his assessments of Mr. Vandyke were rejected by the Department of Labor in adopting the new regulations. *See* 65 Fed. Reg. 79920, 79937-79944 (2000).

After weighing all of the medical opinions of record, I resolve the conflict by according the greatest probative weight to the opinions of Drs. Rosenberg and McSharry. Both possess excellent credentials in the field of pulmonary disease. Both had the opportunity to examine the Claimant as well as to review other medical evidence in the record. I find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by the physicians who concluded that the Claimant has pneumoconiosis. I also find the opinions of Drs. Rosenberg and McSharry to be in better accord both with the evidence underlying their opinions and the overall weight of the medical evidence of record.

Neither the x-ray evidence, nor the biopsy evidence, nor the medical opinion and other evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that there has been no material change in conditions, and no mistake in a determination of fact in the prior denial of this claim, because the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease caused by his exposure to coal dust. Thus he cannot show that he is entitled to benefits under the Act.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he has coal workers’ pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to his in pursuit of this claim.

ORDER

The request for modification filed by Mr. Vandyke on December 27, 2002, is hereby DENIED.

A

Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2004), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.